Vermont Sets Medicaid Precedent

Waiver Program Elevates Status Of Community Care

Vermonters eligible for skilled nursing facility (SNF) services under Medicaid may opt to receive services in their home or in community-based settings under a groundbreaking waiver program.

The Centers for Medicare & Medicaid Services (CMS) recently approved Vermont's Section 1115 waiver application, which establishes home- and community-based services (HCBS) as an entitlement equal to skilled nursing care, while reconfiguring SNF eligibility. The waiver also institutes a state-run patient-assessment program to control admission to SNFs and sets a budget for spending.

The waiver will cover 4,500 Medicaid recipients age 65 and over, as well as adults with physical disabilities. All of Vermont's current SNF patients are eligible, according to conditions of the waiver.

Under the waiver, Vermont has agreed to cap the number of beneficiaries and its Medicaid expenditure growth rate at 7.28 percent per year over the five-year duration.

CMS says Vermont's innovative waiver plan holds the promise of reducing Medicaid's "institutional bias that other states could follow" and incorporates the "money-follows-the-person" concept. CMS will be evaluating the results of this waiver program for future application in other states.

"We are using the approach that has been proven most effective in getting needed support services to more people with disabilities at the lowest cost by allowing the money to follow the beneficiary's own preferences," says CMS Administrator Mark McClellan.

"This program will provide important evidence on how to end the institutional bias in Medicaid and allow people to live in the community when they prefer to do so—without increasing Medicaid costs."

Both the American Health Care Association (AHCA) and the Vermont Health Care Association (VHCA), however, have expressed concerns that the future impact of the waiver program could force some facility closures in the state, while ensuring that the sicker, frailer beneficiaries who do enter SNFs will require higher levels of services at a higher cost.

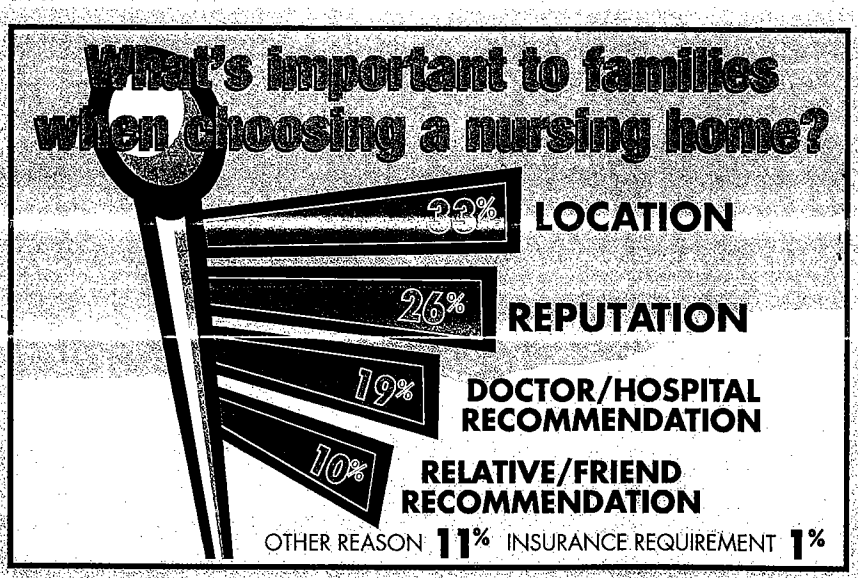
"Even with the dramatic limit to growth, there appears to be an expectation that everyone's needs would be met and that money will be saved because home-based care services are supposedly less expensive," says Janice Zalen, AHCA's senior director of special programs.

AHCA supports allowing beneficiaries to choose their own care settings, Zalen says, as long as the setting is medically appropriate. "We're concerned that those people who would normally be eligible for SNF care will be left out if the state runs out of money," she says.

AHCA and VHCA estimate that some 2,100 Medicaid patients currently in SNFs would be eligible for HCBS under the Vermont waiver. The state will employ a new assessment program to classify long term care beneficiaries into three groups, depending on their level of need. Individuals being assessed as belonging to the "highest needs group" would be given the choice of entering a SNF or receiving HCBS.

The remaining categories of beneficiaries—the "high needs" and "moderate needs" groups—will benefit from earlier and more cost-effective services, according to Vermont's waiver application. The theory is that services such

By The Numbers



Source: Family satisfaction surveys conducted in 2004 in 26 states by My InnerView Inc.™ (www.myinnerview.com)

as a weekly visit from a paid homemaker or a case manager will ultimately stabilize a patient's condition, thereby resulting in postponing admission to a higher level of care, according to the Vermont proposal submitted to CMS on Oct. 1, 2003.

Vermont anticipates cost savings because state officials believe that most future beneficiaries will choose to remain at home, thereby saving the state money on SNF-provided care. Vermont's Commissioner of Aging Patrick Flood told the Barre *Times Argus* that home care costs $28,000 per patient year, while SNF care would cost $54,000. Currently, 1,200 people receive Medicaid-covered care and, under the waiver, the 100 people on a waiting list would get assistance. Vermont's Department of Aging and Disabilities will oversee the development of care plans and expenditures for individuals, according to the waiver plan, a concept conceived as a managed care component of the program.

In addition, the waiver states that Vermont will launch a public information campaign about long term care resources and programs. State officials will educate individuals and families about the state's community-based options.

The state also promised to encourage personal responsibility for long term care costs by developing incentives to encourage individuals to purchase long term care insurance.

—Lisa Gelhaus

Congress Mulls Post-Acute Payments

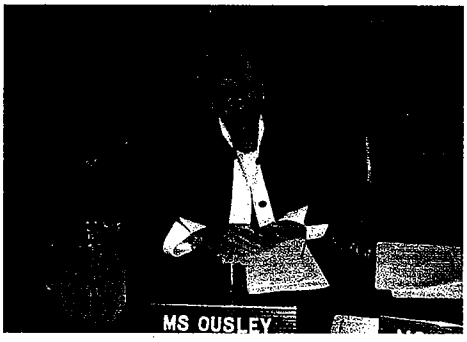
A recent meeting of the House Ways and Means Health subcommittee, chaired by Rep. Nancy Johnson (R-Conn.), focused on the establishment of a uniform assessment tool and payment methodology for the nation's post-acute care system.

Currently Medicare is spending more than $30 billion annually to pay for post-acute care in four different settings: long term care acute hospitals (LTACH), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and patients' homes. But Medicare reimburses these settings according to four separate payment methodologies, and each setting, except for LTACHs, employs its own patient assessment instrument to evaluate the level of care a patients needs.

A representative from each sector of the post-acute care system testified before Johnson's subcommittee.

"When it comes to post-acute care, we now have it backwards; our post-acute payment structure is tied to the institutional setting in which patients are placed—not to the services required by patients," said Mary Ousley, executive vice president of SunBridge Healthcare, Albuquerque, N.M., and immediate past chair of the American Health Care Association/ National Center for Assisted Living.

Congress is seeking to address the lack of uniformity by mandating that the Department of Health and Human Services produce a report on the development of a standardized assessment tool that could gauge the health and functional status of Medicare beneficiaries in the different settings.



Mary Ousley

A spokesman for the Centers for Medicare & Medicaid Services (CMS) testified about the agency's progress in implementing prospective payment methodologies, as well as conducting stakeholder and technical meetings, but he said that reconciling each acute-care setting into one system will require further development.

"By examining the provider-focused prospective payment methodologies and considering patient-focused payment approaches, while developing an integrated assessment tool, CMS is taking a necessary first step toward increased system integration," said Herb Kuhn, director of CMS' Center for Medicare Management.

While post-acute care providers wait for the development of a standardized tool, Ousley said that CMS could improve its placement of patients by giving hospitals a standardized tool to use during Medicare beneficiary discharge planning. Instituting such a tool would further clarify the proper setting for the patient, she said.

"Research, as well as provider experience, shows that different post-acute care settings sometimes serve similar patients," said Ousley. "This overlap in patient populations can occur for legitimate non-clinical reasons or clinical reasons that are not measurable by research. However, the overlap is sometimes inappropriate and results in Medicare overpayment."

A June Medicare Payment Advisory Commission report showed that in 2004, for example, the Medicare payment rate for a patient admitted for a hip fracture was $44,633 at an LTACH, $18,487 at an IRF, and $10,618 at a SNF.

—Lisa Gelhaus